Surgical Technologist Sunrise Review

Information Summary and Recommendations

November 1996

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Legislative Intent

It is the Legislature's intent to permit all qualified individuals to enter a health care profession. If there is an overwhelming need for the state to protect the public, then entry may be restricted. Where such a need to restrict entry and protect the public is identified, the regulation adopted should be set at the least restrictive level.

The Sunrise Act, RCW 18.120.010, states that a health care profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public and the potential for harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public can reasonably benefit from an assurance of initial and continuing professional ability; and
- The public cannot be protected by other more cost effective means.

After evaluating the criteria, if the legislature finds that it is necessary to regulate a health profession not previously regulated by law, the regulation should be consistent with the public interest and the least restrictive method. There are five types of regulation to be considered:

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions, and criminal prohibitions are not sufficient to eradicate existing harm.

2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business when a service is being performed for individuals involving a hazard to the public health, safety, or welfare.

3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practiced and, if required, a description of the service provided. A registrant ~~could be~~ *is* subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

4. *Certification.* A voluntary process by which the state grants recognition to an individual who has met certain qualifications. Non-certified persons may perform the same tasks, but may not use "certified" in the title. A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to persons who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensee is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

Overview of Proceedings

The Department of Health notified the applicant group, all professional associations, board and committee chairs, and staff of the Sunrise Review. Meetings and discussions were held and documents circulated to all interested parties.

Regulatory agencies in all other states were requested to provide sunrise reviews, regulatory standards, or other information which would be useful in evaluating the proposal. A literature review was conducted. Staff have reviewed all submitted information and asked for feedback from interested parties.

An initial public meeting was held on June 3, 1996, to identify the relevant issues and key players. A public hearing was conducted on August 28, 1996. The hearing panel included staff from the Department of Health and a public member. Interested persons were allowed to give presentations. There was an additional ten-day written comment period.

Following the public hearing and additional written comments, a recommendation was made based on all information received and in consultation with the public hearing panel. The proposed final draft was reviewed and approved by the Health Systems Quality Assurance Assistant Secretary and the Department Secretary. The final report was transmitted to the Legislature via the Office of Financial Management.

EXECUTIVE SUMMARY

In January 1996 the House of Representatives forwarded HB 2458 to the department for sunrise review. The proposal under review contains the following:

- Registration of all surgical technologists under the Medical Quality Assurance Commission and/or the Board of Osteopathic Physicians and Surgeons.
- Two requirements for registration (completion of an accredited program and certification by the national association).
- A scope of practice for surgical technologists that includes some tasks limited to the practice of medicine or nursing; for instance, the penetration of tissue.
- A practice plan developed by each surgical technologist and the operating physicians under whom they practice. Plans are approved by the commission/board.
- Inclusion of the surgical technologist under the Uniform Disciplinary Act.

Surgical Technologists are not regulated by the state. They are currently able to perform tasks considered to be under the auspices of medicine in 23 states working under an "exemption clause" in the appropriate medical practice acts. Surgical technologists are the only unregulated profession that routinely practice in the operating room.

Operating room nurses, other professional nurse associations, the Nursing Care Quality Assurance Commission and the Medical Quality Assurance Commission are opposed to the bill whereas the Washington State Hospital Association, many surgeons, and Certified Surgical Technologists are in favor of the bill.

Findings

1. There is general confusion about the definition of surgical assisting, surgical first assisting, and surgical second assisting.

2. HB 2458, as written, is confusing to health personnel and it is misunderstood.

3. Core curriculum for accredited surgical technologist programs does not include skills in suturing, tying or coagulation of bleeding vessels, or other advanced surgical assisting skills that surgical technologists are known to perform.

4. Core curriculum for accredited surgical technologist programs does include skills such as bladder catheterization and use and maintenance of a staple gun. Three programs in Washington are accredited and the fourth is advancing toward accreditation.

5. The surgical technologist who wishes to learn advanced skills (suturing, etc.) is able to obtain this information through continuing education classes and courses.

6. It is the surgeon that delegates to the surgical technologist and first or second assistant during the operation, and it is the registered nurse who supervises the other activities within the operating room, monitors that all events are proceeding according to schedule, maintains safety, etc.

7. No examples of harm were cited including the practice of those surgical technologists who are practicing "out-of-scope" and those that received on-the-job training.

8. A potential for harm exists because: of the inherent danger in surgery; of the delegations and the misunderstandings of the ST role; and because technology for surgery continues to advance at a rapid pace.

9. Credentialing at the level of registration is supported by literature, by some documents received, and by the high level of misunderstanding found among health professionals.

10. There is precedence in Washington law for credentialing a profession when scopes of practice overlap or have been approved formally or informally by health professionals. Literature and other research also supports this.

Recommendations

1. Do not approve House Bill 2458.

2. The Department of Health, in consultation with the Medical Quality Assurance Commission, the Washington State Nursing Care Quality Assurance Commission, the Board of Osteopathic Physicians and Surgeons, the Board of Podiatric Medicine and Surgery, and surgical technologists should determine and disseminate the definitions of the terms: surgical assistant, surgical first assistant, and surgical second assistant.

3. Should the legislature decide to regulate, the department recommends that it be at the level of registration and should occur as a secretary's profession. The department would be available to work with the interested parties on language for such a piece of legislation.

CURRENT REGULATION

Surgical technologists are not regulated by the state. They are currently able to perform tasks considered to be under the auspices of medicine in 23 states working under an "exemption clause" in the appropriate medical practice acts.[1] Surgical technologists are the only unregulated profession that routinely practices in the operating room.

PROPOSAL FOR SUNRISE REVIEW

In January 1996 the House Health Care Committee chair, Representative Phil Dyer, forwarded House Bill 2458 to the Department of Health for sunrise review (see Appendix A). The bill under review contains the following stipulations:

- Registration of all surgical technologists under the Medical Quality Assurance Commission and/or the Board of Osteopathic Physicians and Surgeons.
- Two requirements for registration (completion of an accredited program and certification by the national association).
- A scope of practice for surgical technologists that includes some tasks limited to the practice of medicine or nursing; for instance, the penetration of tissue.
- A practice plan developed by each surgical technologist and the operating physicians under whom they practice. Plans are approved by the commission/board.
- Inclusion of the surgical technologist under the Uniform Disciplinary Act.

DEFINITIONS

In this report, the following terms will be used. The terms and definitions are taken from the applicant's report, surgical technologist literature, or are defined by the department for clarity of this report.

scrub role - The traditional tasks a person performs as part of a surgery team; usually stands next to the physician. Tasks are found in summary of applicant's report which follows (p.10-12).

surgical technologist (ST) - A person who fulfills the scrub role; referred to as ST (singular or plural)

surgical assistant (ST/SA) - A person who is acting in the scrub role, but performing more advanced tasks. This person has received advanced training.

certified surgical technologist (CST) - A surgical technologist who is certified by the national organization and earned the title by completing approved education and passing an approved examination.

first assistant (FA) - A person who assists the surgeon during surgery. It could be a physician, physician assistant (PA), physician assistant surgical assistant (PASA), or registered nurse (RNFA). The person assists with opening and closing incisions, suturing, stapling, assisting with bleeding vessels, or other duties the surgeon may delegate.

certified surgical technologist/certified first assistant (CST/CFA)- A CST who has received advanced training through workshops, seminars, or course work and passed an examination to become a first assistant in surgery. Cannot work in Washington as a first assistant unless credentialed as listed under 'first assistant' above.

INITIAL PUBLIC MEETING

A meeting on June 3, 1996, was attended by interested parties. Representatives from the applicant group explained the bill and answered questions. There was considerable concern over the expanded tasks listed in the bill. The applicant representatives clarified the expanded role as a ***scrub assistant***, not a first or second assistant. In an attempt to clarify the intent of the applicant group, a summary of the meeting was published and answers to specific questions were requested from the applicant (see Appendix B). During this meeting it became evident that ambiguity in the bill's language was the basis of some misunderstandings.

SUMMARY OF INFORMATION

The hearing panel reviewed all documents received during the review process. In this section, documents are paraphrased or quoted and do not reflect the department's findings located in a later section of this report. Complete documentation is disclosable to the public upon request.

Greater Seattle Chapter #78, Association of Surgical Technologists - (applicant) - It is estimated there are 1,314 surgical technologists (ST) practicing in Washington State in hospital operating rooms, ambulatory surgery centers, and physician's private operating suites. About 80% of ST are employed by hospitals, 15% are employed by physicians, and 5% work for agencies. Agency employment is increasing and becoming the trend.

There are four public institutions that offer the surgical technologist course. Three are accredited by an association that accredits allied health courses throughout the U.S. and is connected with the American Medical Association. The fourth will be accredited in a short time. When a program is accredited, the basic education covers skills listed below.[2] *(Note: There were 52 graduates in 1994 and 60 graduates in 1995 in Washington State.)*

The ST role before, during, and after a surgery includes skills, knowledge, and abilities for tasks formerly referred to as the "scrub role". Responsibilities in this traditional role include the following tasks. This list is concise, not inclusive, because basic knowledge of instruments, anatomy, physiology, surgery medications, sterile technique, etc., can be assumed.

- Prepare basic sterile packs and trays.
- Assure the physical preparation of the operating room.
- Identify and select appropriate packs, trays, and accessory/specialty equipment for each surgery.
- Assist with positioning the patient.
- Prepare supplies and instruments for the sterile field.
- Create the sterile field and maintain highest standard of sterile technique during operative procedure.
- Count all instruments, sponges, needles, and other items as dictated by policy.
- Pass correct instrumentation, supplies, and suture as needed by the surgeon.
- Hold retractors to keep surgical field visually open.
- Prepare medication and irrigating solutions as needed.
- Anticipate emergency or unusual circumstances and initiate corrective actions.
- Anticipate the needs of the surgeon in order to expedite the surgical procedure so that the patient is protected from unnecessary time and exposure while under anesthesia.

The association divides the competency statements into seven categories which are listed below (see Appendix C for competency brochure):

1. Demonstrates patient care concepts;
2. Demonstrates the application of the principles of asepsis in a knowledgeable manner to provide optimum patient care;
3. Demonstrates basic surgical case preparation skills;
4. Demonstrates creation and maintenance of the sterile field;
5. Demonstrates the role of the scrub person;
6. Demonstrates accountability as a health care professional.

The national Association of Surgical Technologists, Inc. awards the title Certified Surgical Technologist (CST) to persons who pass an examination administered by the Liaison Council on Certification for the Surgical Technologist. The test is administered by Assessment Systems, Inc., and is based upon a reliable task analysis of the ST practice. Certified Surgical Technologists follow a Code of Ethics and must complete a specific number of continuing education hours to renew their certification. Over 50% of Washington's 93 hospitals hire CSTs to work in their surgery suites.[3] The remaining hospitals (usually smaller hospitals) either have a program for on-the-job training, which may or may not follow national association curriculum guidelines, or they hire experienced ST.

In addition, some surgical technologists, while in the scrub role, assist the surgeon with clamping and tying off bleeding vessels in the opening of incisions, and the suturing and stapling of tissue in the closing of incisions. In the operating room a ST may also be asked to insert a urinary catheter. Currently, these tasks are illegal for the surgical technologist to perform in Washington State because they fall within the scope of practice of medicine and/or nursing. It is for this reason HB 2458 was introduced to the legislature.

The expanded duties of assisting with opening and closing of incisions must be learned through continuing education and/or on-the-job training. This is true for registered nurses as well as ST. These are the duties that a surgeon delegates. During surgery those persons within the sterile field who assist the surgeon (another physician, registered nurse first assistant, physician assistant, physician assistant surgical assistant, and surgical technologist) are working under the delegation of the surgeon who is performing surgery.

In 1989 CSTs with the necessary skills to qualify as a surgical first assistant were licensed under a grandfather clause in the Physician Assistant Surgical Assistant (PASA) law. This action was needed because many ST were practicing as first assistants; the new law legalized their practice. Initially 100 persons were grandfathered as PASA. Current law requires a person to enroll in a physician assistant course to become a PASA. Of the original 100 who were grandfathered as PASA, 41 are still licensed.[4]

But, health care has changed since 1989, and the role of the experienced ST has evolved to a "scrub assistant", or ST/SA, a person to whom the surgeon teaches and/or delegates medical tasks during the opening and closing of incisions. Accordingly, ST have the option of advanced courses in suturing, stapling, and other skills found in first or second assistant roles to the surgeon.

These enhanced tasks involve penetration of tissue and controlling bleeding vessels and are only performed while the supervising physician is in direct contact with the ST/SA. The tasks are performed as part of the scrub role and are not to be confused with a surgical first or second assistant role. The proposed bill allows a CST/CFA, while in the scrub role, to assist the physician in the opening and closing of incisions (suturing, stapling, tying off bleeders) and "other related technical functions, including other tasks determined by the commission/board by rule."

The changing paradigm of medicine has produced different staffing patterns for operating room suites (a higher ratio of technologists per registered nurse),[5 6] and the more highly sophisticated technology now in use requires more knowledge. There is also more equipment in the operating suite. Regulation would benefit the public by placing the ST under the Uniform Disciplinary Act. To avoid sanctions against their credentials, the ST would have to maintain competency and knowledge of new techniques.

Other persons who now perform suturing, stapling, and help to control bleeding vessels are physicians (MD, DO, and DPM), registered nurses who are certified as first assistants (RNFA), Physician Assistants (PA), and Physician Assistants Surgical Assistants (PASA). By registering ST under the Medical Quality Assurance Commission, HB 2458 provides an exemption from other statutes and provides for administrative rules that would restrict the practice of surgical technology to persons who are certified by the national association, and, if they wish to perform expanded tasks (i.e. suturing), they may do so through an amended practice plan after additional education is sought.

National Association of Surgical Technologists -There is a general lack of knowledge about the field of surgical technology and the public is not sure what distinguishes it from the occupation of nursing. Additionally, the public does not have the opportunity to evaluate the qualifications of surgical technologists and must depend upon the standards set by the employer. The standards may vary.

Secondary to reimbursement for medical care, the roles of professionals in the operating room began to change. In 1969 Medicare began decreasing the payment to physicians assisting in the operating room; therefore, physician assistants and registered nurses began to fulfill the role of first assistant to the surgeon leaving the field open for development of a new occupation, the operating room technician, or surgery technician. This was the time when educational standards were established and practice standards were developed for the technician. Up to this time the field of surgical technology was controlled by nurses.

Also, around 1969 registered nurse educational programs began deleting operating room courses from their programs; the nursing shortage of the 1970s and 1980s further deleted the number of nurses working in the operating room. By the late 1980s the role of operating room technicians became more important to the surgeon. For over two decades, the education of operating room technicians has been an accredited allied health program in technical and vocational colleges, and a national examination is administered awarding the title of Certified Surgical Technologist to those persons who pass the examination.

Surgical technology is a specific domain of health care in which surgical intervention, a medical model of health care treatment, is taught. The ST must learn medical/surgical plans of action and evaluation of aseptic and surgical technique. Protecting the patient requires establishment and maintenance of an aseptic environment; it requires speed and dexterity in the handling of

surgical instruments; and it requires the ability to anticipate the surgeon's movements. ST bear the responsibility for recognizing any indications that the sterility of the surgical field or implements has been compromised, and that all instruments are working properly and are readily available for a particular operation. The surgical technologist is educated in the medical model to compliment the physician surgeon.

The nature of surgical technology places the public at sufficient risk to warrant government oversight, and the competencies and test mechanisms are sufficiently proven to allow appropriate control for entry into the profession. There is a movement in health care regulatory arenas by registered nurses to incorporate all unlicensed assistive personnel into nursing. Surgical technologists are not educated in the nursing model and do not practice nursing.

NOTE: many of the following paraphrased documents contained similar comments about technical problems with the bill. In this section the responses are limited mainly to issues about scope of practice.

Washington Hospital Association - The association supports credentialing and the expanded tasks for ST in the bill, but not the bill as it is now written. "Hospitals have been surveyed regarding this bill. Administrators note the amount of delegation of these tasks varies with each surgeon and with each surgical technologist, depending upon the knowledge of the technologist and the trust level between the two practitioners. A review of hospital liability insurance carriers reveals that no adverse patient outcomes can be attributed to the use of these techs [in advanced roles]."

Surgeons in support of the bill - In addition to one letter from some Group Health surgeons, other surgeons wrote to the department in support of this bill. They believe that when surgical technologists are working closely with the surgeon during surgery, the surgeon only delegates to the level of the specific ST experience and education. Patient safety is not compromised. Surgeons have also written to the Washington State Medical Association supporting the credentialing of surgical technologists.

Washington State Medical Association - Physicians value surgical technologists as part of the health care team. While some level of regulation might be appropriate at some time, we oppose this bill which would make ST the equivalent of physician's assistants without the required education. The bill fails to meet the criteria for sunrise approval.

Medical Quality Assurance Commission - Medical professionals are all under pressure to do more. To allow surgical technologists to expand their scope of practice into areas defined as "the practice of medicine" will cloud the issue more than clarify it. Today, it is clear that they can do nothing defined under the scope of medicine. The next commission newsletter contains an article about improper delegation to unlicensed personnel.

The duties of the ST given in the bill are all under the scope of practice of registered nurses; and it would be appropriate to be regulated by the Nursing Care Quality Assurance Commission. If ST wish to further their practice, it is best to pursue avenues of education to be a registered nurse or physician assistant.

In addition, the MQAC asserts that the Group Health surgeons who signed a letter sent to the department do not support the bill or any level of credentialing for surgical technologists.

Washington State Nursing Care Quality Assurance Commission - Surgical technologists should not be permitted to circulate within the operating room. National standards of the Association of Operating Room Nurses require a registered nurse as the circulator, and the Joint Commission on Accreditation of Healthcare Organizations refers to the qualified registered nurse as performing circulating duties. Also, if surgical technologists are regulated as a new category of provider, an exemption clause should be added for nurses.

Operating Room Nurses - Seventy-three letters were received by the Department of Health from operating room nurses and Washington chapters of the Association of Operating Room Nurses (AORN) who oppose this bill. They believe that:

- ST are not educated to fulfill duties other than the traditional scrub role;
- The quality of care must not be compromised for the cost of care;
- The quality of care will decrease when a lesser educated person is allowed to perform tasks associated with other licenses that require more education;
- ST are not educated or qualified to circulate and/or be in charge of the operating room;
- More education is needed for an expanded scope of practice;
- ST work under the supervision of a nurse, not a physician.

Local 1199, SEIU - There are risks inherent in the bill's proposed expansion of practice. It is inappropriate to replace either registered nurses who circulate or registered nurses/physician assistants who are first assistants with surgical technologists. Additionally, the union states:

> "Such tasks as suturing, applying staples, clamping tissue, tying or cauterizing vessels, require more than the technical skill of performing the procedure. The advanced training of professionals who can now assist in these procedures under the supervision of the physician is needed to ensure the safety of the patient. The professional education provides a level of training in anatomy and physiology, pathology, and integration of numerous other areas that are not found in the technical training of the surgical technicians."

A less costly employee does not address the issues of quality care and safe practice. There is no harm to the public with the current unregulated practice. The applicant group did not meet the requirements of the sunrise statute.

Local 1001, UFCW - The union supports the addition of an exemption clause in the physicians and nurse practice acts.

Washington State Nurses Association - The applicants and proponents of the surgical technologists proposal have failed to meet any of the statutory-mandated sunrise criteria required by law. There is no potential harm or benefit to the public. The problem is improper surgeon delegation of surgical tasks.

Additionally, there is no shortage of qualified staff to properly perform these tasks. The bill and testimony shows that ST believe they possess a much higher level of competence than their training indicates and this is not realistic.

The generality of the terms in the bill are also of concern. As testified at the hearing, a 'plan' could be under the direction of more that 65 physicians. Unfortunately, the plan could be reduced to a sham removing the idea of a meaningful, enforceable, safe practice agreement.

Washington Association of Nurse Anesthetists - Our organization has a long history of being involved in the development and support of health care delivery which is cost-effective, easily accessible and safe. The proposal submitted is not in the public interest. The education and training of surgical technologists does not prepare them to perform the activities listed in the Sunrise Review Application.

Washington State Council of Perioperative Nurses - The role of surgical technologists is to assist in surgeries working under the supervision of a registered nurse. This bill would broadly redefine their role to include tasks that surgical technologists are not educated to perform.

Association of Operating Room Nurses - There is no need for regulation of the practice of the surgical technologist. They are not independent practitioners and always work under the direction of a physician or registered nurse. The purpose of the system for protection of the public is to qualify providers and discipline those who do not meet practice standards and qualifications. The system does not dictate reporting relationships in individual work settings.

PUBLIC HEARING

A public hearing was held on August 28, 1996. Twenty-five people testified. Present at the hearing were four applicant representatives, 15 registered nurses representing operating room nurses, representatives or staff from the Medical Quality Assurance Commission, Nursing Quality Assurance Commission, Podiatry Board, Board of Osteopathic Physicians and Surgeons, State Board of Health, Washington State Nurses Association, Washington State Medical Association, LU 1199 NW, the Washington Academy of Physician Assistants, and the Washington Osteopathic Medical Association.

An Options Paper was circulated before the hearing to all interested parties with the intent of soliciting testimony pro or con for one or more of the options (see Appendix D). Five issues were identified from the Initial Public Meeting, applicant report, and correspondence. Each issue had one or more options for resolution. The five issues are:

1. Based on sunrise criteria of harm and/or benefit to the public, should this profession be regulated, and if so, at what level?
2. Surgical technologists are limited in their traditional role in the state of Washington because they are not exempted from performing certain tasks.
3. Under the proposed bill, is supervision of ST the sole responsibility of the physician named on the practice plan?
4. Are surgical technologists educated to circulate in the operating room?
5. Are surgical technologists educated to perform enhanced skills in the operating room?

The hearing began at 8:30 a.m. and ended at 1:15 p.m. Testimony was overwhelmingly against the bill as written with the exception of the four representatives from the applicant group. Major problems with HB 2458 identified in testimony include:

- Registration at a level of licensing which requires specific education and examination;
- Placement of a new category of profession under auspices of Medical Quality Assurance Commission;
- Development of practice plans that may include 65 or more physicians;
- Acting as circulator in the operating room; and
- Allowing the practice of advanced skills with or without appropriate education

Post-hearing: At the end of the hearing, panel members believed all present supported regulation at the level of registration. Written comments and rebuttal statements received during the posthearing comment period show that regulation is not supported, and in fact, except for the applicant, all professional groups, health professional Commissions and Boards are against any type of regulation. The department received several written comments augmenting oral presentations given at the hearing.

FINDINGS

1. **There is general confusion about the definition of surgical assisting, surgical first assisting, and surgical second assisting.**

2. **HB 2458, as written, is confusing to other health personnel and it is misunderstood.** For example, the bill has education requirements for a registered profession which, by definition, cannot have such requirements. Additionally, the bill requires advanced education for advanced skills if those skills are included in a 'practice plan'.

3. **Core curriculum for accredited surgical technologist programs does not include skills such as suturing, tying or coagulation of bleeding vessels, or other advanced surgical assisting skills that surgical technologists are known to perform.**

4. **Core curriculum for accredited surgical technologist programs does include skills such as bladder catheterization and maintenance and use of the staple gun**. It is the ST that must assemble, load, and reload the gun during the surgery. The actual use of the staple gun requires penetration of tissue which is defined by law as a medical procedure. Stapling the tissue is commonly performed by Washington ST as well as ST in other states. Both stapling and bladder catheterization are taught during the basic educational program.

5. **The surgical technologist who wishes to learn more advanced skills is able to obtain this information through continuing education classes and courses.** There is an examination for a certified surgical technologist who, upon passing, becomes a certified first assistant (CST/CFA). The CST/CFA is also not able to penetrate tissue, catheterize, or perform other expanded tasks in the State of Washington.

6. **It is the surgeon that delegates to the surgical technologist and first or second assistant during the operation, and it is the registered nurse who supervises the other activities within the operating room, monitors that all events are proceeding according to schedule, maintains safety, etc**. Eighty percent of surgical technologists work for the hospital in which they practice and, as a hospital employee, work under a supervisor. Most operating room supervisors are registered nurses. During the actual surgery, the first assistant and surgical technologist are responsible to the surgeon, to anticipate the surgeon's need and demands.

   When the surgery is finished, if the first assistant and ST are employed by the hospital, they observe the operating room organizational chart regarding who is the supervisor. For example, a PASA works for Group Health Cooperative. During surgery she is responsible to the surgeon and during the remainder of her day she is supervised by the person named on the Group Health/operating room organizational chart.

7. **There are no examples of harm to a patient by surgical technologists including technologists who are practicing the traditional scrub role, technologists that are practicing "out-of-scope" (or beyond the traditional scrub role), and those that have received on-the-job training.**

8. **A potential for harm exists because: of the inherent danger in surgery; of the delegations and the misunderstandings of the ST role; and because technology for surgery continues to advance at a rapid pace.**

9. **Credentialing at the level of registration is supported by literature, by some documents received, and by the high level of misunderstanding found among health professionals.** The Washington State Hospital Association supports credentialing and letters of support from surgeons have also been received by DOH and the medical association.

Health care is becoming more complex. Rapid technological advances, increased competition among health personnel, and transformation of the health care financing and delivery systems are drivers for credentialing, particularly in a highly regulated setting like the surgery suite.[7] [8] When the legislature finds it is necessary to regulate a health profession, the least restrictive alternative regulation method should be implemented consistent with the public interest; where the threat to public health is relatively small, regulation should require registration as the credentialing level.[9]

Registration could decrease the cost of surgery secondary to using a lower paid but competent person to assist the surgeon. The assumption that unlicensed personnel are unskilled or uneducated is misleading. However, the perception that using unlicensed personnel may save money needs to be carefully calculated. Policy, position statements, staffing models, and care standards must be based on the skills, education and credentials needed to perform.[10]

A revised bill could define tasks of a surgical technologist that would be understood by all employers and practitioners. Definitions would serve to protect the public in a highly regulated health care atmosphere (operating room as well as health care system) where the concepts appear to be misunderstood. Regulation would bring the surgical technologists under the auspices of the Uniform Disciplinary Act. This will become even more important as surgical technology continues to advance and newer equipment is introduced into the operating room.

10. **There is precedence in Washington law for credentialing a profession when scopes of practice overlap or have been approved formally or informally by health professionals.** Many ST are practicing beyond the scope of the traditional scrub role, and the practice has been sanctioned by physicians and nurses in the operating room. The Medical Quality Assurance Commission is notifying all physicians that it is illegal to delegate a task for which a license is needed to an unlicensed individual.

The state of Maine conducted a policy review of regulation and practice acts. They found that licensing inadvertently creates or fosters professional monopolies because licensing has traditionally defined who can or cannot provide certain services and perform certain

functions. This produces a system that fails to recognize overlapping skills and competencies."[11] Health literature contains numerous references to overlapping practice: [12 13 14 15 16] For example:

- Education, and training that prepare health professionals to deliver practice that overlaps with other establish practices;
- The consumers right to choose from a range of safe options using qualified, lower cost, medically sound providers;
- Flexible regulation to support optimal access to a competent workforce; and
- Multiskilled workers.

The practice of unlicensed personnel was not a problem until their tasks began to overlap the scopes of practice of established professions. When Medicare moved to DRGs in 1983, the three largest payers of health care, federal government, state/local government and employers, were affected and the search for more affordable care began. [17]

Through the 1980's and early 1990's literature has steadfastly maintained that adding new regulated professions assists in developing monopolies and that deregulation allows marketplace competition; but for marketplace competition to work, the entire industry must be deregulated (i.e. freight transportation, airlines, New York Stock Exchange, telecommunications). There are three primary reasons for deregulation: 1) increased regulatory costs to groups with a concentrated interest; 2) erosion of monopoly profits; and 3) the courts and antitrust.[18] The US health care system is highly regulated but, it is believed that eventually antitrust actions and erosion of monopoly profits will force changes in health care regulation.[19] However, until regulation changes, the problem of overlapping scopes of practice will continue.

Additionally, overlapping scopes of practice have been defined in Washington law. For example:

- In 1989, some ST's were practicing in an overlapping scope and were credentialed as PASA's. They fulfill the role of a surgical first assistant.
- Advanced Registered Nurse Practitioners (ARNP) who must be certified by their specific national association before being licensed as an ARNP.
- Physical therapists, who may use massage techniques in treatment plans.
- Ophthalmologist and optometrist.
- Physician and physician assistant.

RECOMMENDATIONS

1. **Do not approve House Bill 2458.**

   Rationale:
   - The bill is confusing and misleading to health system personnel.
   - There are too many technical flaws for the concepts presented to be implemented.
   - The benefit to the public from expanded duties as listed for surgical technologists has not been shown clearly enough to justify state regulation as proposed.

2. **The Department of Health, in consultation with the Medical Quality Assurance Commission, the Washington State Nursing Care Quality Assurance Commission, the Board of Osteopathic Physicians and Surgeons, and the Board of Podiatric Medicine and Surgery, and surgical technologists should determine and disseminate the definitions of the terms: surgical assistant, surgical first assistant, and surgical second assistant.**

   Rationale:
   - Confusion currently exists among the professionals involved in surgery and other health professionals about each of these terms and how they are defined. A cooperative effort to define the terms for everyone's use would be helpful in alleviating the confusion.

3. **Should the legislature decide to regulate, the department recommends that is be at the level of registration and should occur as a secretary's profession. The department would be available to work with the interested parties on language for such a piece of legislation.**

   Rationale:
   - In large part because of the confusion surrounding current practice, current regulation, the exact wording of the proposed bill, the apparent intent of the applicant, and other factors, it was hard to conclude the sunrise criteria had been met sufficiently to impose regulation. However, there may be a benefit to some low level of state regulation, and if the legislature decides that is the case, the department can work with it and other interested parties on a bill.

REBUTTAL STATEMENTS

The department received rebuttal statements to the recommendations from five organizations. It was originally planned to copy the statements as received; but, since the recommendations were renumbered, the rebuttal statements would not follow in order leading to confusion and misunderstandings.

The rebuttal statements have been reorganized and they are true to the original document unless a statement or paragraph did not address a specific recommendation or did not make sense given the new order.

RECOMMENDATION 1. House Bill 2458 should not be approved as written.

There are no rebuttal statements to this recommendation.

RECOMMENDATION 2. The Department of Health, in consultation with the Medical Quality Assurance Commission, the Washington State Nursing Care Quality Assurance Commission, the Board of Osteopathic Physicians and Surgeons, and the Board of Podiatric Medicine and Surgery, and surgical technologists should determine the definitions of the terms: surgical assistant, surgical first assistant, and surgical second assistant.

* * * * *

"The reason for this task . . . is not convincing. A great deal of work has been done that clarifies the operating room roles. We believe stricter enforcement of existing roles would lead to improved understanding of those roles in the operating room and provide more safety to patients."

- *District 1199 NW SEIU, AFL-CIO*

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". . . confusion arises from introducing new terms where traditional ones suffice, e.g., first assistant, scrub person, circulator. . . . Surgeons delegate to the assistants during the operation, and RNs supervise the assistive personnel in the operating room when the surgeon is not present, including surgical technologists. The duties of the scrub person and the first assistant should never overlap. It is the responsibility of the first assistant to hold retractors, to keep the surgical field visually open, and to staple tissue. The expanded duties of first assisting, such as opening and closing of incisions and stapling tissue, must be learned through a didactic course of education, followed by direct experience under the supervision of a physician preceptor. It is currently illegal for STs to be practicing beyond the scope of the traditional scrub role. This practice is not sanctioned by AORN and perioperative nurses. AORN objects to on-the-job training of technicians working in the operating room; all health care professionals would object to on-the-job training for surgical procedures."

- *Association of Operating Room Nurse, Inc.*

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"Some confusion may exist among the public, and such an endeavor may be truly beneficial. However, the confusion . . . may have arisen more from the distortion of the terms' meaning in the surgical technologists' proposal and comments than from any widespread confusion among professionals over the meaning and common usage of these terms."

- *Washington State Nurses Association*

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". . . it is necessary to clarify who (unlicensed surgical technologist or license PA, SA, RN) is acting in these roles and which tasks or activities may be performed according to the law. . . .

Even if there is confusion about the definitions of first assisting, second assisting, and scrub role, the Medical Practice Act and the Nurse Practice Act clearly state what activities are legal to perform by surgical technologists in each role. These activities are under the delegation authority of the Nurse Practice

Act. . . of the registered nurse and the Medical Practice Act of the surgeon. The field of surgical technology is an occupation, not a profession, and surgical technologists function under the direction, supervision, and delegation of the registered nurse and the surgeon." - *Chapter 4804, Spokane, AORN*
- *Washington State Council of Perioperative Nurses*

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RECOMMENDATION 3. Should the legislature decide to regulate, the department concludes that registration of surgical technologists should occur as a secretary's profession and that the following suggestions be considered:

A. Their title would be Registered Surgical Technologist (RST).

* * * * *

"The field of surgical technology is an occupation not a profession and surgical technologists function under the direction, supervision, and delegation of the registered nurse and the surgeon. . . .

[The] Surgical technologist occupation should not be recognized as a profession without possessing the characteristics of a profession: continual development of a scientific body of knowledge, broadening the knowledge base with research, fostering commitment and accountability to patients and the profession, active and cohesive professional organization, meeting the advanced educational requirements, clinical skills and experience, and addressing the area of discretionary authority and judgment. . . .

Registration of surgical technologists is not necessary or cost effective. No examples of harm were found! None of the three conditions for a health profession to be regulated have been met. Registration does not establish or monitor standards for initial or continued competence."
- *Chapter 4804, Spokane, AORN*
- *Washington State Council of Perioperative Nurses*

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"The proponents for the bill failed to cite evidence that the public has been harmed by not regulating surgical technologists (STs). Recommendations for registration, should legislation proceed, does not ensure initial and continuing professional ability; the public is already being protected through the oversight of STs by physicians and registered nurses. Furthermore, "RST" is a new term that only will confuse the public, who it was found is confused already about the role

of the ST. STs, who work under the authority of physicians and registered nurses (RNs), are generally considered within an occupation."

- *Association of Operating Room Nurses, Inc.*

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". . . at both the [initial public meeting] and the hearing itself, the issue of registration seemed to be confused because the proponents linked it to training. . . . We support the approach being taken by the Medical Quality Assurance Commission which has sent [sic] a letter to physicians informing them of their violation or potential violation of the law if they are responsible for unlicensed practice."

- *District 1199 NW SEIU, AFL-CIO*

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". . . The materials submitted in support of this proposal by the Association of Surgical Technologists have failed to meet the statutory requirements of benefit to the public. Instead, they use the justification that the financial constraints of managed care are increasing the use of surgical technologists in the operating room, and they want to be able to perform all the tasks asked of them.

In fact, there is no potential harm to the public from current regulatory practice, nor would regulatory changes benefit the public. Rather than imposing new state regulation, there are better alternatives for action. Existing laws regarding surgical, medical, and nursing practice should be obeyed and enforced. Furthermore, surgical technologists should refuse the illegal orders of those surgeons and facilities who ask them to practice medicine or nursing without a license. . .

Any potential danger to the public health is not from lack of state regulation of surgical technologists. The problem is rather that surgical technologists are being asked by some surgeons and facilities to practice in a manner which is dangerous, to conduct tasks which they are prohibited from performing under the Medical Practice Act or the Nurse Practice Act. If current laws were obeyed by surgical technologists, by refusing to perform such tasks, there would be no danger to the public.

There is no shortage of qualified, trained staff able, willing, and licensed to perform all of the expanded tasks sought by the surgical technologists, including physicians, physician assistants, and registered nurses. There is quite simply **no need** for recognition of a new profession."

- *Washington State Nurses Association*

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Recommendation #3

B. RSTs should be defined as a practitioner that can demonstrate the following basic tasks:

- ☒ patient care concepts for the operating room;
- ☒ preparing the patient for surgery including bladder catheterization and positioning;
- ☒ application of the principles of asepsis to provide optimum patient care;
- ☒ basic surgical case preparation skills;
- ☒ creation and maintenance of the sterile field;
- ☒ passing instruments and maintaining the equipment needed by the surgeon;
- ☒ stapling tissue under direct supervision of the surgeon; and
- ☒ accountability as a health care professional.

* * * * *

"The omission of 'circulating in the operating room' from the demonstrated tasks for a registered surgical technologist may not be clear enough. Please add that this role does not include circulating in the operating room." - *Nursing Care Quality Assurance Commission*

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"Though the proposal only proposes registration by the state, it establishes an exclusive, legally-defined scope of practice with training and practice standards. The Practical effect is that of a licensure proposal. Registration is only an administrative process, but this proposal in fact goes much further. . . .

. . . we oppose the expansion from the traditional "scrub" role . . . allowing surgical technologists to perform "preparing the patient for surgery including bladder catheterization and positioning" and "stapling tissue under direct supervision of the surgeon". We feel that these tasks are outside the training and expertise of the surgical technologist, and should continue to be prohibited. Though the surgical technologist currently may assist the registered nurse in positioning the patient in the operating room, the independent role is one for which they are not trained. The recommendation to allow an exemption from the Medical Practice Act to permit surgical technologists to catheterize and pierce tissue is of even greater concern."

. . . contrary to the surgical technologists assertions, registered nurses (particularly certified operating room nurses) are more qualified than surgical technologists to perform operating room duties such as circulating and surgical assisting. Registered nurses receive extensive education regarding anatomy, physiology, and sterile procedures which

is superior to that of surgical technologists. Registered nurses possess knowledge about the complete health of the patient, not just the narrow knowledge acquired in surgical technologist training programs. Unlike surgical technologists, registered nurses are educated to assess and utilize professional judgment in recognizing and responding to problems with a surgical patient's health before, during, and after operative procedures. In their proposal, the surgical technologists falsely claim they possess this level of knowledge and expertise."

- *Washington State Nurses Association*

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"This is a training requirement that appears to be not enforceable with registration. In addition, the proposed list of tasks would expand the practice of surgical technologists and could lead to more confusion about their role in the operating room such as determining which surgical technologists have the demonstrated skills and which do not. Currently, as stated by the surgical technologists in the hearing, some surgeons are pressuring them to perform tasks that require licensure. Creating a list does not address the issue of pressure to perform other tasks that may not be on the list. We believe this also increases the potential for harm. In addition, we strongly feel that task-oriented training does not substitute for the comprehensive skills required to perform in the first assistant role or circulating role and that these roles should not be confused with that of a surgical technologist."

- *District 1199 NW SEIU, AFL-CIO*

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"The surgeon, who applies for privileges at the hospitals at which he/she operates, agrees to abide by the policies of that facility as well as within the law and may only delegate certain activities to an unlicensed surgical technologist. If a surgical technologist wishes to perform activities such as penetration of tissue, suturing, opening and closing incisions, tying and cauterizing bleeding vessels, he/she should get the additional education . . . for that role such as . . . nurse, physician's assistant, or surgeons' assistant. . . .

Preparing the patient for surgery is the responsibility of the registered nurse. Although female bladder catheterization and patient positioning are taught in the two year curriculum in the Spokane area, these activities require the use of the nursing process (assessment, planning, implementation, and evaluation) as well as the knowledge and skills to perform the procedures and are not endorsed or practiced by surgical technologists in the Spokane area hospitals. Surgical technologists occasionally assist the registered nurse and surgeon in positioning the patient for surgery. Surgeons and registered nurses insert catheters into

the bladder and position patients for surgery and retain the responsibility for these procedures/activities. The anesthesia provider assists with positioning also and retains responsibility for some components of patient positioning. . . .

Scopes of practice do not really overlap; surgeons are delegating activities to the unlicensed surgical technologist that are not legal to delegate except to licensed professionals."

- *Chapter 4804, Spokane, AORN*
- *Washington State Council of Perioperative Nurses*

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"The list of demonstrated tasks provided . . . does not clarify the role of the [surgical technologist]; it is too general and would lead to confusion and misinterpretation. Furthermore, AORN members at the hearing do not recall having the issue of bladder catheterization and patient positioning discussed at all. AORN, therefore, objects to the inclusion of these tasks in the definition of tasks performed by RSTs. . . .

"Surgical technologists who work under the authority of physicians and registered nurses . . . are generally considered within an occupation and not a profession since they do not have autonomy in their work and are not personally responsible for the services that they provide. . . .

The scrub person almost never positions or assists in positioning a patient, since she/he is scrubbed at this point in the surgery. It is the responsibility of the first assistant to hold retractors, to keep the surgical field visually open, to staple tissue for the surgeon and to insert urinary catheters. These are not scrub functions."

- *Association of Operating Room Nurses, Inc.*

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C. An advisory committee should be appointed. The committee membership should include RSTs, public members, surgeons, registered nurse representing operating room nurses, and physician assistants with experience in the operating room.

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"AORN requests more representation of nurses on any advisory committee purporting to oversee STs. According to testimony of the Medical Quality Assurance Commission at the hearing, 'all duties of the ST in the bill are currently under the scope of practice of registered nurses.' Since the bill proposes to usurp responsibilities of registered nurses as currently found in the nursing practices act, at least two perioperative nurses should be included on the proposed advisory committee. . ." - *Association of Operating Room Nurses, Inc.*

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"The make-up of this committee is lacking in representation from the physicians assistants. We would recommend adding two physicians assistants and two registered nurses representing operating room nurses because all other categories are represented by two members."

- *District 1199 NW SEIU, AFL-CIO*

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"In the event that an advisory committee is appointed, two operating room nurses are as necessary as two surgeons since surgical technologists function under the direction, supervision, and delegation of the registered nurse as well as the surgeon. . . "

- *Chapter 4804, Spokane, AORN*
- *Washington State Council of Perioperative Nurses*

* * * * *

"Physician assistants should be added to the advisory committee."

- Medical Quality Assurance Commission

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APPENDIX A

House Bill 2458

H-3497.3

HOUSE BILL 2458

State of Washington 54th Legislature 1996 Regular Session

By Representatives Backlund, Dyer and Crouse

Read first time . Referred to Committee on .

AN ACT Relating to registration of surgical technologists; amending RCW 18.71.030 and 18.57.040; adding new sections to chapter 18.71 RCW; and adding new sections to chapter 18.57 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 18.71.030 and 1995 c 65 s 1 are each amended to read as follows:

Nothing in this chapter shall be construed to apply to or interfere in any way with the practice of religion or any kind of treatment by prayer; nor shall anything in this chapter be construed to prohibit:

(1) The furnishing of medical assistance in cases of emergency requiring immediate attention;

(2) The domestic administration of family remedies;

(3) The administration of oral medication of any nature to students by public school district employees or private elementary or secondary school employees as provided for in chapter 28A.210 RCW;

(4) The practice of dentistry, osteopathy, osteopathy and surgery, nursing, chiropractic, podiatric medicine and surgery, optometry, naturopathy, or any other healing art licensed under the methods or means permitted by such license;

(5) The practice of medicine in this state by any commissioned medical officer serving in the armed forces of the United States or public health service or any medical officer on duty with the United States veterans administration while such medical officer is engaged in the performance of the duties prescribed for him or her by the laws and regulations of the United States;

(6) The practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state;

(7) The practice of medicine by a person who is a regular student in a school of medicine approved and accredited by the commission, however, the performance of such services be only pursuant to a regular course of instruction or assignments from his or her instructor, or that such services are performed only under the supervision and control of a person licensed pursuant to this chapter;

(8) The practice of medicine by a person serving a period of postgraduate medical training in a program of clinical medical training sponsored by a college or university in this state or by a hospital accredited in this state, however, the performance of such services shall be only pursuant to his or her duties as a trainee;

(9) The practice of medicine by a person who is regularly enrolled in a physician assistant program approved by the commission, however, the performance of such services shall be only pursuant to a regular course of instruction in said program and such services are performed only under the supervision and control of a person licensed pursuant to this chapter;

(10) The practice of medicine by a licensed physician assistant which practice is performed under the supervision and control of a physician licensed pursuant to this chapter;

(11) The practice of medicine, in any part of this state which shares a common border with Canada and which is surrounded on three sides by water, by a physician licensed to practice medicine and surgery in Canada or any province or territory thereof;

(12) The administration of nondental anesthesia by a dentist who has completed a residency in anesthesiology at a school of medicine approved by the commission, however, a dentist allowed to administer nondental anesthesia shall do so only under authorization of the patient's attending surgeon, obstetrician, or psychiatrist, and the

commission has jurisdiction to discipline a dentist practicing under this exemption and enjoin or suspend such dentist from the practice of nondental anesthesia according to this chapter and chapter 18.130 RCW;

(13) Emergency lifesaving service rendered by a physician's trained emergency medical service intermediate life support technician and paramedic, as defined in RCW 18.71.200, if the emergency lifesaving service is rendered under the responsible supervision and control of a licensed physician;

(14) The provision of clean, intermittent bladder catheterization for students by public school district employees or private school employees as provided for in RCW 18.79.290 and 28A.210.280;

(15) The practice of surgical technology under the supervision and control of a physician licensed under this chapter by a person registered as a "surgical technologist" under sections 2 through 6 of this act.

NEW SECTION. Sec. 2. (1) No person may practice or represent himself or herself as a surgical technologist without being registered as a surgical technologist under sections 2 through 6 of this act.

(2) No surgical technologist may be employed or supervised by a hospital or physician without a practice arrangement approved by the commission. The supervising physician and surgical technologist are professionally and personally responsible for any act performed by the surgical technologist that constitutes the practice of medicine under this chapter.

(3) The commission and the board of osteopathic medicine and surgery shall consult in the adoption of uniform rules to implement the provisions of this chapter.

NEW SECTION. Sec. 3. (1) "Surgical technologist" means a person registered under sections 2 through 6 of this act to practice surgical assisting only under the supervision and control of a physician licensed under this chapter.

(2) The "practice of surgical assisting" consists of the preparation of the operating room and the instruments, equipment and supplies, passing instruments, sutures, and sponges to the surgeon at sterile field and assist in circulating and positioning and preparing the patient for surgery, under the direct supervision of a registered nurse. It involves those tasks which assist the surgeon in the opening

and closing of incisions and other related technical functions under the supervision and control of the surgeon, including other tasks determined by the commission by rule.

NEW SECTION. Sec. 4. (1) The commission shall approve applicants for registration who meet the requirements of sections 2 through 6 of this act. The commission may require an approved practice arrangement plan before a surgical technologist may be employed or supervised by a hospital or physician. The commission shall require AIDS prevention training of registrants and may adopt requirements for continuing education.

(2) An applicant for registration must demonstrate to the satisfaction of the commission that he or she has successfully completed an educational program accredited by a national accrediting organization approved by the commission and has been certified by a national certifying organization in surgical technology determined by the commission. No examination is required for registration, however the commission may require any examination it deems necessary to determine the applicant's physical or mental capability to safely practice as a surgical technologist.

(3) The commission shall adopt rules to implement the registration of surgical technologists under sections 2 through 6 of this act.

NEW SECTION. Sec. 5. (1) Upon the approval of the commission, the secretary shall issue a registration to any applicant who submits, on forms provided by the secretary, the applicant's name, address, name and place of business or employer, and other information required by the commission under sections 2 through 6 of this act. The registration must be renewed annually.

(2) The secretary shall determine registration and application fees pursuant to RCW 43.70.250.

NEW SECTION. Sec. 6. The uniform disciplinary act, chapter 18.130 RCW, governs the issuance and denial of registration, unauthorized practice, and the discipline of persons registered under sections 2 through 6 of this act. The commission is the disciplining authority under sections 2 through 6 of this act.

Sec. 7. RCW 18.57.040 and 1991 c 160 s 5 are each amended to read as follows:

Nothing in this chapter shall be construed to prohibit:

(1) Service in the case of emergency;

(2) The domestic administration of family remedies;

(3) The practice of midwifery as permitted under chapter 18.50 RCW;

(4) The practice of osteopathic medicine and surgery by any commissioned medical officer in the United States government or military service or by any osteopathic physician and surgeon employed by a federal agency, in the discharge of his or her official duties;

(5) Practice by a dentist licensed under chapter 18.32 RCW when engaged exclusively in the practice of dentistry;

(6) Practice by any osteopathic physician and surgeon from any other state or territory in which he or she resides: PROVIDED, That such practitioner shall not open an office or appoint a place of meeting patients or receive calls within the limits of this state;

(7) Practice by a person who is a student enrolled in an accredited school of osteopathic medicine and surgery approved by the board: PROVIDED, That the performance of such services be only pursuant to a course of instruction or assignments from his or her instructor or school, and such services are performed only under the supervision of a person licensed pursuant to this chapter or chapter 18.71 RCW;

(8) Practice by an osteopathic physician and surgeon serving a period of clinical postgraduate medical training in a postgraduate program approved by the board: PROVIDED, That the performance of such services be only pursuant to a course of instruction in said program, and said services are performed only under the supervision and control of a person licensed pursuant to this chapter or chapter 18.71 RCW; ((~~or~~))

(9) Practice by a person who is enrolled in a physician assistant program approved by the board who is performing such services only pursuant to a course of instruction in said program: PROVIDED, That such services are performed only under the supervision and control of a person licensed pursuant to this chapter or chapter 18.71 RCW; or

(10) The practice of surgical technology under the supervision and control of a physician licensed under this chapter by a person registered as a "surgical technologist" under sections 9 through 12 of this act.

This chapter shall not be construed to apply in any manner to any other system or method of treating the sick or afflicted or to apply to or interfere in any way with the practice of religion or any kind of treatment by prayer.

NEW SECTION. Sec. 8. (1) No person may practice or represent himself or herself as a surgical technologist without being registered as a surgical technologist under sections 8 through 12 of this act.

(2) No surgical technologist may be employed or supervised by a hospital or physician without a practice arrangement approved by the board. The supervising physician and surgical technologist are professionally and personally responsible for any act performed by the surgical technologist that constitutes the practice of medicine under this chapter.

(3) The commission and the board of osteopathic medicine and surgery shall consult in the adoption of uniform rules to implement the provisions of this chapter.

NEW SECTION. Sec. 9. (1) "Surgical technologist" means a person registered under sections 8 through 12 of this act to practice surgical assisting only under the supervision and control of a physician licensed under this chapter.

(2) The "practice of surgical assisting" consists of the preparation of the operating room and the instruments, equipment and supplies, passing instruments, sutures, and sponges to the surgeon at sterile field and assist in circulating and positioning and preparing the patient for surgery, under the direct supervision of a registered nurse. It involves those tasks which assist the surgeon in the opening and closing of incisions and other related technical functions under the supervision and control of the surgeon, including other tasks determined by the commission by rule.

NEW SECTION. Sec. 10. (1) The board shall approve applicants for registration who meet the requirements of sections 8 through 12 of this act. The board may require an approved practice arrangement plan before a surgical technologist may be employed or supervised by a hospital or physician. The board shall require AIDS prevention training of registrants and may adopt requirements for continuing education.

(2) An applicant for registration must demonstrate to the satisfaction of the board that he or she has successfully completed an educational program accredited by a national accrediting organization approved by the board and has been certified by a national certifying organization in surgical technology determined by the board. No examination is required for registration, however the board may require any examination it deems necessary to determine the applicant's physical or mental capability to safely practice as a surgical technologist.

(3) The board shall adopt rules to implement the registration of surgical technologists under sections 8 through 12 of this act.

NEW SECTION. Sec. 11. (1) Upon the approval of the board, the secretary shall issue a registration to any applicant who submits, on forms provided by the secretary, the applicant's name, address, name and place of business or employer, and other information required by the board under sections 8 through 12 of this act. The registration must be renewed annually.

(2) The secretary shall determine registration and application fees pursuant to RCW 43.70.250.

NEW SECTION. Sec. 12. The uniform disciplinary act, chapter 18.130 RCW, governs the issuance and denial of registration, unauthorized practice, and the discipline of persons registered under sections 8 through 12 of this act. The board is the disciplining authority under sections 8 through 12 of this act.

NEW SECTION. Sec. 13. (1) Sections 2 through 6 of this act are each added to chapter 18.71 RCW.

(2) Sections 8 through 12 of this act are each added to chapter 18.57 RCW.

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APPENDIX B

Competency Pamphlet, AST

ESSENTIALS AND GUIDELINES
for
ACCREDITED EDUCATIONAL PROGRAMS IN SURGICAL TECHNOLOGY

Essentials adopted in 1972
Revised in 1991

Adopted by the
American College of Surgeons
American Hospital Association
Association of Surgical Technologists
and the
American Medical Association

Guidelines adopted in 1980
Revised in 1990

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) grants accreditation to programs in surgical technology upon the recommendation of the Accreditation Review Committee for Education Programs in Surgical Technology.

These Essentials are the minimum standards of quality used in accrediting programs that prepare individuals to enter the profession of surgical technology. The extent to which a program complies with these standards determines its accreditation status; therefore, the Essentials constitute the minimum requirements to which an accredited program is held accountable. The Essentials are printed in regular typeface in outline form.

The Guidelines accompanying the Essentials provide examples intended to assist in interpreting the Essentials. Guidelines are printed in italic typeface in narrative form.

Sections I and III of these Essentials are common to all educational programs accredited by CAAHEP. Section II contains the specific requirements for preparing surgical technologists.

PREAMBLE

OBJECTIVE

The American College of Surgeons, American Hospital Association, Association of Surgical Technologists, and Commission on Accreditation of Allied Health Education Programs cooperate to establish, maintain, and promote appropriate standards of quality for educational programs in surgical technology and to provide recognition for educational programs that meet or exceed the minimum standards outlined in these Essentials.

These standards are to be used for the development, evaluation, and self-analysis of surgical technology programs. On-site review teams assist in the evaluation of a program's relative compliance with the Essentials.

A list of accredited programs is published for the information of students, employers, educational institutions and agencies, and the public.

SECTION I: GENERAL REQUIREMENTS FOR ACCREDITATION

A. SPONSORSHIP

1. Sponsoring Institution and Affiliates

The sponsoring institution and affiliates, if any, must be accredited by recognized agencies or meet equivalent standards.

In programs in which didactic and clinical supervised practice are provided by two or more institutions, responsibilities for program administration, instruction, supervision, and other functions of the sponsoring institutions and of each affiliate must be clearly described in written documents, such as an affiliation agreement or memorandum of understanding.

The clinical phase of the educational program must be conducted in a clinical setting under competent clinical direction.

Guideline

Recognized agencies are those acceptable to the United States Department of Education. Hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations, American Osteopathic Association, or the United States Health Care Financing Administration are acceptable as clinical affiliates. Other institutions may also be acceptable if they meet equivalent standards.

A copy of the written affiliation agreement, signed by appropriate officers, should be maintained by each institution. This agreement should be periodically reviewed and should also include a termination clause with sufficient notice to protect enrolled students.

2. Programs Eligible for Accreditation

Educational programs eligible for accreditation shall be established in one of the following:

a. Community, technical and junior colleges, senior colleges, and universities

b. Hospitals and clinics

c. Postsecondary vocational/technical schools and institutions, including educational programs within all branches of the armed services

d. Proprietary schools

e. Other institutions or consortia that meet comparable standards for education in surgical technology

3. Sponsoring Institution Responsibilities

The sponsoring institution assumes primary responsibility for student admission, curriculum planning, selection of course content, coordination of classroom teaching and supervised clinical practice, appointment of faculty, receiving and processing applications for admission, and granting the certificate or degree documenting satisfactory completion of the educational program. The sponsoring institution shall also be responsible for providing assurance that the practice activities assigned to students in a clinical setting are appropriate to the program.

B. RESOURCES

1. Personnel

a. Administrative Personnel

The program must have adequate leadership and management.

b. Program Director/Coordinator or Equivalent

(1) Responsibilities

In addition to other assigned responsibilities, the director/coordinator of the educational program shall be responsible for the organization, administration, continuous review, planning, development, and general effectiveness of the program. The director/coordinator shall be sufficiently free from service and other noneducational responsibilities to fulfill the educational and administrative responsibilities indicated.

(2) Qualifications

The director/coordinator of the educational program shall be qualified in terms of academic preparation, teaching abilities, and knowledge of the surgical environment and shall meet the educational standards for faculty as required by the institution.

Guideline

It is recognized that there are organizational differences and that the director/coordinator may not be an operating room professional; however, he/she should possess a working knowledge of the program's clinical activities.

c. Faculty and/or Instructional Staff

(1) Responsibilities

In each location where a student is assigned for didactic or supervised clinical practice, there must be a qualified individual designated to provide instruction, supervision, and evaluation of the student's progress in achieving program requirements.

Guideline

Instructors in didactic courses should be aware of the overall organization and objectives of the educational program and should be familiar with the outcome knowledge and skills expected of students in the clinical facilities.

A method should be established for providing adequate communication between the clinical affiliate sites and the sponsoring institution.

(2) Qualifications

The instructors must be knowledgeable in course content and effective in teaching their assigned subjects.

Guideline

Instruction should be conducted by faculty who meet the educational and work experience requirements of postsecondary educational institutions. Programs should assure that all courses are taught by instructors having qualifications appropriate to the course being taught and that those instructors have current knowledge in that subject.

In securing qualified faculty, careful attention should be given to communication skills such as listening, interviewing, counseling, and a knowledge of behavioral sciences.

Instructors who have had no surgical technology experience may be qualified to provide didactic instruction in such subjects as anatomy, physiology, pathology, microbiology, and pharmacology. Programs should exercise care in selecting faculty for these subjects.

A faculty member who is teaching surgical technology courses should be a certified surgical technologist (CST) or a certified nurse–operating room (CNOR). The faculty member should have appropriate educational background and three years or more of current clinical experience in the operating room.

A clinical instructor should be a CST, CNOR, or otherwise acceptable person with current surgical technology experience. A clinical instructor should be qualified to teach clinical skills and should be sufficiently free from noneducational responsibilities to fulfill the instructional responsibilities required. In addition, the instructor should understand the teaching and evaluation methodologies being used in the total instructional process.

When an instructor in either the didactic or clinical environment has limited background, the program director/coordinator should carefully select the best instructor for each phase of the program.

Current curricula vitae for the surgical technology faculty and clinical instructor(s) should be on file with the program.

(3) Number

There shall be sufficient faculty to provide students with adequate attention, instruction, and supervised practice to acquire the knowledge and competence needed for entry into the profession.

Guideline

The ratio of students to faculty will vary according to the learning objectives and teaching methods used in any given instructional period. Of principle concern is that the students receive not only the group and individualized instruction required to accomplish the defined learning opportunities, but also that tutorial/individualized instructional services should be available for students requiring assistance in attaining the stated objectives of the program.

d. Clerical and Support Staff

Adequate clerical and other support staff shall be available.

e. Professional Development

Programs shall provide the opportunity for all program staff and faculty to pursue continuing professional growth. Faculty and staff have a responsibility to make optimal use of these opportunities.

Guideline

Planned programs of professional development should be designed to enhance the instructors' backgrounds in the areas of their greatest needs. The focus of professional development should be the educational process and should include formal credit and noncredit experiences. Individuals having no previous instructional experience should be given initial education in learning theory, instructional methods, evaluation, and an overview of the learning and teaching process. Professional development should also stress current knowledge regarding clinical practices and standards.

Faculty and staff should provide documentation of participation in professional development.

2. Financial Resources

The sponsoring institution shall ensure adequate financial resources to fulfill obligations to matriculating and enrolled students.

Guideline

The program should have the financial and attitudinal support of senior administrative officers. Financial support through budgetary allocations should allow for the salaries of administrative, instructional, secretarial, clerical, and other support staff, as well as for instructional materials, office supplies, staff travel associated with clinical coordination and instruction, staff participation in professional development, and student and alumni services.

3. Physical Resources

a. Facilities

Adequate classrooms, laboratories, clinical and other facilities, and administrative offices shall be provided.

Guideline

Classrooms should meet or exceed state requirements regarding such factors as adequate lighting, ventilation, and furnishings for student use. Adequate space should be provided for interviewing, counseling, and student/faculty conferences.

If a laboratory setting is within a clinical facility, the affiliation agreement should document assurance of adequate availability of appropriate resources.

Offices for instructional staff should be reasonably accessible and suitably private for planning, evaluation, and counseling activities. Security for student records, instructional materials, examinations, and other appropriate program-related materials should be provided.

b. Equipment and Supplies

Appropriate and sufficient equipment, supplies, and storage space shall be provided for student use and for teaching the didactic and supervised clinical practice components of the curriculum. Instructional aids, reference materials, supplies and equipment, and demonstration materials must be provided when required by the types of learning experiences delineated for either the didactic or supervised clinical education components of the curriculum.

Guideline

The laboratory setting should contain the following items of furniture and supplies: operating table with standard attachments, instrument/back table, Mayo stand, prep stand, intravenous pole, transport stretcher, ring stand, sitting stool, basic instruments, scrub sink, catheters, blood pressure device, draping materials, sutures and needles, wrappers, gowns, gloves, masks, caps, sheets, antiseptic soap, soap dispenser, brushes, and other appropriate items. Equipment should reflect what is currently in use in the clinical area. A plan for increasing inventory and replacing outmoded equipment should be in place.

There should be a posted schedule of hours when laboratory facilities are available to students to foster self-instruction.

c. Learning Resources

(1) Library

Students shall have ready access to an adequate supply of current books, journals, periodicals, and other reference materials related to the curriculum.

Guideline

The library should contain standard and contemporary texts as well as related articles and periodicals in surgical technology. There should be services of a staff librarian available to assist students. The library should be accessible when the students have free time, and the flow of materials should be controlled to allow opportunity for them to circulate among students.

(2) Instructional Aids

Any related reference materials, models, computer hardware and software, and audiovisual resources shall be available in sufficient number and quality to enhance student learning.

C. STUDENTS

1. Admission Policies and Procedures

Admission of students, including advanced placement, shall be made according to clearly defined and published practices of the institution. Any specific requirements for admission to the program shall be clearly defined and published and readily accessible to prospective students and the public.

Any policies regarding advanced placement, transfer of credit, and credit for experiential learning shall be readily accessible to prospective students.

Guideline

In academic institutions, selection of students should be made according with the generally accepted practice of the institution. In hospital-sponsored programs, selection of students should be made by an admissions committee in cooperation with those responsible for the educational program. Selection criteria should be evaluated periodically to determine the correlation with student performance and attrition. Admissions data should be on file.

Applicants lacking prerequisite competencies should be counseled for appropriate remediation prior to program acceptance in order to reduce potential attrition and to permit the program faculty to concentrate on the didactic and clinical education required by the curriculum.

2. Student Evaluations

Criteria for successful completion of each segment of the curriculum and for graduation shall be given in advance to each student. Evaluation methods (systems) shall include content related to the objectives and competencies described in the curriculum for both didactic and supervised clinical education components. They shall be employed frequently enough to provide students and program officials with timely indications of the students' progress and academic standing and to serve as a reliable indicator of the effectiveness of course design and instruction.

Guideline

Keyed copies of written and practical examinations should be maintained on file and continually evaluated in terms of their validity, reliability, interpretability, and appropriateness.

Students should be evaluated through clinical observations and written evaluations on a regular basis during the clinical components of the program. These evaluations should be provided at appropriate intervals relative to the distribution of clinical hours. Evaluation results should be shared with the student to provide him/her the opportunity to respond and to focus on areas needing improvement.

A satisfactory record system should be provided for all student performance.

Enrolled students should have ample time to correct identified deficiencies in knowledge and/or performance prior to completion of the program.

3. Health

The program officials shall establish a procedure for determining that the applicants' or students' health will permit them to meet the requirements of the program and clinical sites. Students must be informed of and have access to the health care services provided to other students of the institution.

Guideline

Successful applicants should be required to submit evidence of good health and appropriate immunizations. In both didactic and clinical settings, health services should be provided for the evaluation and maintenance of students' health. When students are in a clinical setting, they should have the same physical examinations and immunizations as are required of hospital employees in the same clinical setting.

4. Guidance

Guidance shall be available to assist students in understanding and observing program policies and practices, to provide counseling or referral for problems that may interfere with the students' progress through the program, and to provide career counseling.

Guideline

Students should have ready access to faculty for advice regarding their academic concerns and employment opportunities and to professionally qualified staff for help with personal concerns and problems. Resource personnel should be available to advise students regarding implementing a job search, writing a resume, completing employment applications, and preparing for the employment interviewing process.

D. OPERATIONAL POLICIES

1. Fair Practices

a. Publication of Information

Publications and advertising must accurately reflect the program offered.

Guideline

Official publications should include information regarding the organization of the program, a brief description of required courses, names and academic rank of faculty, entrance requirements, tuition and fees, and information concerning hospitals and other facilities used for clinical experience.

b. Nondiscriminatory Practices

Student recruitment and admission and faculty recruitment and employment practices shall be nondiscriminatory with respect to race, ethnicity, creed, sex, age, disabling conditions (handicaps), and national origins.

c. Student Costs

Tuition, fees, and other costs to the student shall be accurately stated, published, and made known to all applicants.

Guideline

Materials should describe all costs to be borne by the students and all services to which the costs entitle the students. Student travel and transportation requirements should be clearly stated.

d. Student or Faculty Grievances

The program or sponsoring institution shall have a defined and published policy and procedure for processing student or faculty grievances.

Guideline

Students should be informed of due process practices with regard to admission and retention policies, unfavorable evaluations, and disciplinary policies such as those for suspension and dismissal.

A faculty grievance policy should be defined and the stages of the process should be clearly outlined.

e. Student Withdrawal

Policies and processes for student withdrawal and for refunds of tuition and fees shall be published and made known to all applicants.

f. Student Work Policy

Students must not be substituted for paid personnel to conduct the work of the clinical facility. However, after demonstrating proficiency, students may be permitted to undertake certain defined activities with appropriate supervision and direction.

Guideline

Clinical phases of instruction should be educational. The substitution of students for regular departmental staff in performing departmental services is not considered to be educationally directed and therefore should not be used to fulfill the clinical requirements of the program.

g. Health and Safety

The health and safety of patients, students, and faculty associated with the educational activities of the students must be adequately safeguarded.

Guideline

Current guidelines from the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) should be followed at all times.

2. Student Records

Each student shall provide evidence of high school graduation or graduate equivalence (GED).

Records shall be maintained for student admission, health, attendance, and evaluation of all academic and clinical activities. Grades and credits for courses shall be recorded on each student's transcript and permanently maintained by the sponsoring institution in a safe and accessible location.

Guideline

A report of medical examination upon admission and records of any subsequent illness or injury should be retained by the sponsoring institution. Attendance and grades should be suitably recorded. Appropriate classroom, laboratory, and clinical records for each student should be maintained by the faculty and retained in the institution for approximately five years. Locked storage should be provided to assure the maintenance of confidentiality for student and program records.

E. PROGRAM EVALUATION

The program must have a continuing system for reviewing the effectiveness of the educational program and must prepare timely self-study reports to aid the staff, sponsoring institution, and accrediting agencies in assessing program qualities and needs.

1. Outcomes

Programs shall routinely secure sufficient qualitative and quantitative information regarding the program's graduates to demonstrate an ongoing evaluation of outcomes consistent with the graduation competencies specified by the educational program.

Guideline

The manner in which programs seek to comply with this criterion may vary. However, there should be timely efforts made to document the input, data, and analyses utilized. Sources of data may include, but should not be limited to, surveys of graduates and employers on such matters as employment settings, type and scope of practice, salary, job satisfaction, education and skills sufficiently and inadequately addressed in the educational program; interviews with program graduates and employers of graduates; and data on the evaluation of graduate performance on the national certifying examination.

2. Results of Ongoing Program Evaluation

The results of ongoing evaluation must be appropriately reflected in the curriculum and other dimensions of the program.

Guideline

Program evaluation should be a continuing, systematic process with internal and external curriculum validation in consultation with employers, surgeons, faculty, preceptors, students, and graduates, with follow-up studies of their employment and national certifying examination performance. Other dimensions of the program merit consideration as well, such as the admission criteria and process, the curriculum design and content, and the purpose and productivity of an advisory committee. If an advisory committee is utilized, it should function according to the policies of the sponsoring institution.

SECTION II. REQUIREMENTS FOR SURGICAL TECHNOLOGY

A. DESCRIPTION OF THE PROFESSION

Surgical technologists are integral members of the surgical team who work closely with surgeons, anesthesiologists, registered nurses, and other surgical personnel delivering patient care before, during, and after surgery. Scrub, circulating, and second assisting surgical technologists have primary responsibility for maintaining the sterile field, being constantly vigilant that all members of the team adhere to aseptic technique.

It is recognized that not all surgical technology practitioners fill the roles of circulator and second assistant. It is imperative, however, that the surgical technology student be educated in all aspects of surgical technology, identified by the following duties and the curriculum content section.

1. Scrub Surgical Technologist

   The scrub surgical technologist handles the instruments, supplies, and equipment necessary during the surgical procedure. He/she has an understanding of the procedure being performed and anticipates the needs of the surgeon. He/she has the necessary knowledge and ability to ensure quality patient care during the operative procedure and is constantly on vigil for maintenance of the sterile field. Duties include but are not exclusive to the following:

   a. Checks supplies and equipment needed for surgical procedure.

   b. Scrubs, gowns, and gloves.

   c. Sets up sterile table with instruments, supplies, equipment, and medications/solutions needed for procedure.

   d. Performs appropriate counts with circulator.

   e. Gowns and gloves surgeon and assistants.

   f. Helps in draping sterile field.

   g. Passes instruments and other appropriate items to surgeon and assistants during procedure.

   h. Maintains highest standard of sterile technique during procedure.

   i. Prepares sterile dressings.

   j. Cleans and prepares instruments for terminal sterilization.

   k. Assists other members of team with terminal cleaning of room.

   l. Assists in preparing room for next patient.

2. Circulating Surgical Technologist

   The circulating surgical technologist obtains additional instruments, supplies, and equipment necessary while the surgical procedure is in progress. He/she monitors conditions in the operating room and constantly assesses the needs of the patient and surgical team. Duties include but are not exclusive to the following:

a. Obtains appropriate sterile and unsterile items needed for procedure.

b. Opens sterile supplies.

c. Checks patient's chart, identifies patient, verifies surgery to be performed with consent forms, and brings patient to assigned operating room.

d. Transfers patient to operating room table.

e. Assesses comfort and safety measures and provides verbal and tactile reassurance to patient.

f. Assists anesthesia personnel.

g. Positions patient, using appropriate equipment and safety measures.

h. Applies electrosurgical grounding pads, tourniquets, monitors, etc., using appropriate safety measure.

i. Positions and operates equipment needed for procedure.

j. Prepares patient's skin prior to draping by surgical team.

k. Performs appropriate counts with scrub person.

l. Anticipates additional supplies needed during procedure.

m. Keeps accurate records throughout procedure.

n. Properly cares for specimens.

o. Secures dressings after incision closure.

p. Helps transport patient to recovery room.

q. Assists in cleaning of room and preparing for next patient.

3. Second Assisting Technologist

The second assisting surgical technologist assists the surgeon and/or first assistant during the operative procedure by carrying out technical tasks other than cutting, clamping, and suturing of tissue. This role is distinct from that of the first assistant and may, in some circumstances, be performed at the same time as the scrub role. Duties include but are not exclusive to the following:

a. Holds retractors or instruments as directed by surgeon.

b. Sponges or suctions operative site.

c. Applies electrocautery to clamps on bleeders.

d. Cuts suture material as directed by surgeon.

e. Connects drains to suction apparatus.

f. Applies dressings to closed wound.

B. CURRICULUM

1. Program Description

Faculty and students shall be provided with a clear description of the program and its content, including learning goals, course objectives, supervised clinical practice assignments, and competencies required for graduation.

2. Instructional Plan

Instruction must follow a plan that documents the following:

a. Appropriate learning experiences and curriculum sequencing to develop the competencies necessary for graduation, including appropriate instructional materials, classroom presentations, discussions, demonstrations, and supervised practice.

b. Clearly written course syllabi that describe learning objectives and competencies to be achieved for both didactic and supervised clinical education components.

c. Frequent, documented evaluation of students to assess their acquisition of knowledge, problem identification and problem-solving skills, and psychomotor, behavioral, and clinical competencies.

Guideline

A master copy of the complete curriculum should be kept on file with the program director/coordinator. The complete curriculum kept on file should include all modifications and recent changes. Copies of course outlines, class schedules, record of clinical experience, multimedia instructional aids, and teaching plans should be on file and available for review.

Students and instructors should be familiar with the behavioral and educational objectives of the program. Objectives should be developed for both the didactic and clinical courses and should be utilized when evaluating the cognitive, psychomotor, and affective skills included in the curriculum.

The requirements for a degree or certificate of completion should be consistent with the requirements for other degrees or certificates awarded by the institution.

3. Curriculum Content

General courses or topics of study, both didactic and clinical, may include the following:

a. Orientation to Surgical Care

(1) Legal, ethical, and moral aspects that relate to the individual patient, operating room hazards, handling of surgical specimens and patient property, operating room records, and required counts and operating room behavior

(2) Hospital and operating room organizational structures

(3) Hospital and operating room organizational structures and professional roles

b. Basic Sciences

(1) Anatomy and physiology: integumentary, skeletal, muscular, nervous (including special sense organs), circulatory, lymphatic, respiratory, digestive, genitourinary, reproductive, and endocrine systems

(2) Microbiology: structure and function of the microbial cell, pathogenic and nonpathogenic organisms, infectious processes, and immune responses

(3) Pharmacology: anesthetic agents and the drugs used in surgery, including their action and use, methods used to measure and calculate dosages, and preparation and handling of drugs and solutions

c. Preparation for Surgery

(1) Preoperative routines: laboratory reports, patient identification, consents, and patient assessment

(2) Transportation: modes of patient transportation and associated precautions

(3) Positioning: variations and precautions in patient positioning and use of equipment for positioning

(4) Patient care procedures: skin preparation, catheterization, vital signs, emergency procedures, and cardiopulmonary resuscitation

d. Fundamentals of Surgical Care

(1) Purposes and methods of sterilization, disinfection, and antisepsis

(2) Packaging, storing, and dispensing surgical supplies

(3) Aseptic technique

(4) Purpose and principles for maintaining environmental safety, including handling of surgical specimens and body fluids, required counts, electrical hazards, radiation and laser precautions, fire safety, and CDC and OSHA requirements

(5) Purpose and principles for maintaining environmental control

(6) Wound healing, including types and classifications of wounds, stages of wound healing, and wound complications

(7) Catheters, drains, tubes, and collecting mechanisms

(8) Preparation and care of surgical supplies and equipment

(9) Types of specialty supplies and equipment

(10) Responsibilities in the scrub and circulating roles

(11) Classifications of instruments sutures, and needles

(12) Surgical packings and dressings

e. Surgical Procedures

Didactic instruction shall include the following surgical specialties:

(1) General and gastrointestinal surgery

(2) Obstetric and gynecologic surgery

(3) Ophthalmic surgery

(4) Ear, nose, and throat surgery

(5) Dental, oral, and maxillofacial surgery

(6) Urologic surgery

(7) Orthopedic surgery

(8) Plastic and reconstructive surgery

(9) Neurosurgery

(10) Thoracic surgery

(11) Cardiovascular surgery

(12) Peripheral vascular surgery

(13) Pediatric surgery

For each of the surgical specialties, instruction shall include the following:

(1) Pathology that prompts surgical intervention

(2) Instruments, suturing materials, and supplies for selected procedures

(3) Method of anesthesia

(4) Patient positioning

(5) Skin preparation

(6) Draping

(7) Incisions

(8) Procedure descriptions, including possible complications

(9) Special medications

Guideline

The following information regarding hours of instruction may serve as a general guide, with recognition that variations may be acceptable.

(1) Of currently accredited nine-month programs, the hours of instruction have an average distribution of 400 to 500 hours of didactic instruction and 500 to 600 hours of supervised clinical experience.

(2) Student selection criteria may have an impact on the length of the program. Military training programs in certain branches of the armed services, for example, require prerequisite preparation before entry into the surgical technology program and may have a curriculum of a highly concentrated nature.

(3) The maximum length of the programs presently in operation is two academic years (18 months), covering an average of 2,000 hours of education and leading to an associate degree. Additional subjects may include liberal arts/general education courses as required by the sponsoring institution.

Students should have laboratory and/or clinical orientation to a variety of special equipment, such as orthopedic equipment, dermatomes, tourniquets, suction units, endoscopes, microscopes, cryotherapy units, electrosurgical units, irrigation/aspiration (I/A) units, laser equipment, monitors, and emergency equipment.

f. Supervised Clinical Practice

The student shall demonstrate a safe level of practice and knowledge in all of the aforementioned areas.

Guideline

If time permits, some structured learning in related areas such as emergency room, central supply, recovery room, and labor-delivery room may be beneficial.

g. Communication and Behavioral Sciences

(1) Effective listening and interpersonal relations

(2) Verbal and nonverbal methods of communication

(3) Appropriate response to psychosocial stress in the patient and within the surgical team

Guideline

Communication and behavioral sciences instruction should include discussion of a patient's emotional responses to his/her illness and surgery. This instruction should also prepare the student to cope with stressful operating room situations including the disfigurement, incurability, or death of a patient.

The legal, moral, and ethical aspects of health care service should include exploration of personal decision-making processes.

III. MAINTAINING AND ADMINISTERING ACCREDITATION

A. PROGRAM AND SPONSORING INSTITUTION RESPONSIBILITIES

1. Application for Accreditation

The accreditation review process conducted by CAAHEP can be initiated by the chief executive officer or an officially designated representative of the sponsoring institution.

The process is initiated by requesting an application form from and returning it to:

Accreditation Review Committee on
Education in Surgical Technology (ARC-ST)
7108-C South Alton Way
Englewood, CO 80112-2106
303-694-9262

At any time before the final accreditation action is made by CAAHEP, a program or sponsoring institution may withdraw its request for initial or continuing accreditation.

2. Administrative Requirements for Maintaining Accreditation

To maintain accreditation, the following actions are required:

a. The program must submit a **Self-Study Report** or a required progress report within a reasonable period of time, as determined by the ARC-ST.

Guideline

The program director/coordinator should be responsible for a self-analysis of the program on a periodic basis. Proper completion of the application forms for initial or continuing accreditation of the program satisfies the self-analysis report requirement of CAAHEP.

b. The program must agree to a reasonable site visit date before the end of the period for which accreditation was awarded.

c. The program must inform the ARC-ST within a reasonable period of time of changes in the positions of program director/coordinator or full-time surgical technology faculty or of substantive changes in clinical affiliation sites.

d. The sponsoring institution must inform CAAHEP and the ARC-ST of its intent to transfer program sponsorship, in accord with CAAHEP policy.

e. The program and the sponsoring institution must pay the ARC-ST and CAAHEP accreditation fees within a reasonable period of time, as determined by the ARC-ST and CAAHEP respectively.

f. The program must complete and return by the established deadline the **Annual Report** provided by CAAHEP to ensure an accurate listing of the program and its sponsoring institution in the annual publication of the national directory of CAAHEP-accredited programs.

Failure to meet these administrative requirements for maintaining accreditation may lead to being placed on Administrative Probation and ultimately to having accreditation withdrawn.

B. CAAHEP AND REVIEW COMMITTEE RESPONSIBILITIES

1. Administration of Accreditation Review Process

At the written request of the chief executive officer or other officially designated representative, CAAHEP and the ARC-ST assess an applicant program's relative compliance with the Essentials.

The accreditation review process includes an on-site evaluation of the program. If the performance of a site visit team is unacceptable, the institution may request a second visit.

Before the ARC-ST formulates its accreditation recommendation to CAAHEP, the sponsoring institution is given an opportunity to comment in writing on the report of the site visit team and to correct factual errors.

Before recommending Probationary Accreditation to CAAHEP, the ARC-ST provides the sponsoring institution with an opportunity to respond in writing to the cited deficiencies in the program's relative compliance with the Essentials. The ARC-ST's reconsideration of a recommendation for Probationary Accreditation is made on the basis of conditions existing when the review committee arrived at its recommendation to CAAHEP and on subsequent documented evidence of corrected deficiencies provided by the applicant.

CAAHEP assignments of Probationary Accreditation, including those following ARC-ST reconsideration, are final and are not eligible for further appeal.

2. Withholding or Withdrawing Accreditation

Before recommending Accreditation Withheld or Accreditation Withdrawn to CAAHEP, the ARC-ST provides the sponsoring institution an opportunity to request reconsideration. Decisions to withhold or withdraw accreditation my be appealed. A copy of the CAAHEP appeals procedures for Accreditation Withheld or Accreditation Withdrawn accompanies the letter notifying the sponsoring institution of one of these actions. When accreditation is withdrawn or withheld, the institutional sponsor's chief executive officer is provided with a clear statement of each deficiency in the program's relative compliance with the Essentials and is informed that application for accreditation as a new applicant may be made whenever the program considers itself to be in compliance with the Essentials.

All students successfully completing a program that holds accreditation at any point during their enrollment are regarded as graduates of a CAAHEP-accredited program.

3. Inactive Programs

The sponsoring institution may request inactive status for a program that does not enroll students for up to two years. The program and its sponsoring institution must continue to pay required annual fees. Should a program be inactive for two years and determine not to reactivate, it will be considered discontinued and accreditation will be withdrawn.

APPENDIX C

Paper on Initial Public Meeting

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47851 • Olympia, Washington 98504-7851

Office of Health Services Development
Sunrise Review
Registration of Surgical Technologists
1996 Regular Session, House Bill 2458

Summary of Initial Public Meeting
June 3, 1996

Persons in Attendance

Panel Members:	Todd Bacon, DOH/HR	Jane Boyajian, DOH/OCRH
	Shirley Dunn, Public Member	
Interested Parties:	Nick Federici, WSNA	Steve Lindstrom, AAW
	Debora Link, SEIU	Robin Logan, WSNA/AORN
	Ellie Menzies, SEIU	Carl Nelson, WSMA
	Janice Olmsted, AST	Jonathan Randolph, AST
	Trevor Sandison, ASC	C.J. Welter, RNFAC

Groups identified as needing to be contacted

Medical Quality Assurance Commission
Board of Osteopathic Medicine and Surgery
Washington Association of Physician Assistants
Washington State Nursing Care Quality Assurance Commission

Summary of discussion

- Bill amends statutes for the Medical Quality Assurance Commission (MQAC) and the Board of Osteopathic Medicine and Surgery.
- Two changes will be made to bill by the applicant:
  1. P.3,L.36 & P6,L.25 - strike "direct supervision of a registered nurse." and insert "JACHO guidelines."
  2. P.4,L14 & P.7,L.4 - add "/or" after the word 'and'
- The word 'commission' needs to be clarified to indicate the Medical Quality Assurance Commission (MQAC).
- Hospitals employ 80% of Surgical Technologists (ST); 15% are employed by physicians and 5% are employed by agencies. The trend is toward more agency employment and less hospital employment.
- Ratio of RN to ST is 60 RN:ST 40. With managed care or 'work redesign' the ratio is changing to 50:50.

- Registration is mandatory and all STs would register, but the bill does not give immunity to RNs; therefore, all RNs who act as first assist or as scrub nurse would have to register with the MQAC as a ST.
- Registration, by law, cannot require education.
- Would physician supervision be the same as what is now done for physician assistants? Who would approve the 'practice plans'? Are they permissive or mandatory?
- Applicants will provide organizational structure of national organization showing relationship to the testing and certifying organization.
- There are concerns with changes in law to meet pressures of managed care; these changes may not be in the best interest of the public (patient).
- Applicant report must discuss the protection of the public (patient) versus the protection of a scope of practice, plus how unregulated practice harms or endangers the public (patient).

- Bill requires completion of regular coursework plus successful completion of an examination to become registered as a ST.
- Bill allows STs to be registered with the Medical Quality Assurance Commission and allows a scope of practice to include the following tasks.

  Under the JACHO guidelines the ST is responsible for:

  1. preparation of operating room, equipment and supplies
  2. passing instruments, sutures and sponges to surgeon
  3. assist in circulating, positioning and preparing patient

  Under the supervision and control of the surgeon the ST may:

  1. assist in the opening and closing of incisions
  2. assist in other related technical functions including other tasks determined by the commission by rule.
- Since 1989 the formal education of STs has included first assisting skills: cutting, penetrating, and directly cauterizing tissue; clamping vessels; and suturing tissue to include deep tying of tissue.
- STs are also taught catherization.
- STs are frequently requested by surgeons to complete the tasks listed above (second set) which are not legal for STs in Washington state.
- STs cannot apply these skills in Washington due to medical practice act. Problem is unique to the state. By placing registration of STs under MQAC, technologists would be able to act as a surgical first assistant, an expanded role from what is now practiced and a role consistent with providing direct, quality patient care.
- In 35 states STs can staple and suture tissue.
- Applicant will research Washington law to determine if the term 'surgical assisting' means first assisting. Bill needs to be more clear to decrease ambiguity.
- Applicant will research laws to determine whether language for scope of practice is adequate or if the language should be more detailed. Present language allows for a scope of practice to be established by rule.
- Bill does not address reimbursement issue; however, the MQAC determines 'arrangement between physician and ST'.
- The burden of accountability now lies with the RN and the hospital; this bill would place the burden of accountability on the physician and hospital. There is a question about the RN responsible for the operating room; is this RN still accountable for ST tasks but without authority?
- There is a concern with the training issue because RN first assistants take educational courses for first assisting in addition to RN coursework whereas ST first assistants would require on-the-job training for some first assistant tasks.
- Applicant will research question on whether or not Washington is accountable to JACHO guidelines, and the number of hospitals in Washington without JACHO accreditation.

APPENDIX D

Hearing Options Paper

OPTIONS FOR RECOMMENDATION

Surgical Technologist Sunrise Review

Public Hearing - August 1996

This bill allows for registration of surgical technologists under the Medical Quality Assurance Commission and/or the Board of Osteopathic Medicine and Surgery. Registration under either of these acts will exempt surgical technologists from other professions' practice acts and allow them to practice the common skills performed in other states under official practice plans submitted to and approved by the commission or board listed above.

NOTE: The options presented below are for focusing the discussion at the public hearing on August 28th. These options currently receive the most attention from the review panel. They are NOT draft recommendations. These options are NOT designed to limit discussion.

Issue #1: Based on sunrise criteria of harm and/or benefit to the public, should this profession be regulated, and if so, at what level?

Option A: Regulate surgical technologists (ST's) at level of registration under the Medical Quality Assurance Commission or the Board of Osteopathic Medicine and Surgery as proposed.

Rationale: The general public does not have the opportunity to evaluate the qualifications of surgical technologists and must depend upon the standards set by the employer, standards which vary in many hospitals. Regulation will:

- Standardize the work tasks of ST's;
- Help the public become more aware of this type of provider, resulting in a benefit to the public;
- Bring ST's under the Uniform Disciplinary Act (UDA) allowing disciplinary action for incompetent ST's;
- Provide exemption from other laws that restrict skills the ST can provide;
- Provide for quality in work tasks through the Practice Plan developed by the commission and the board;
- Allow for less cost to the patient through the expanded Practice Plan.

Option B: Regulate ST's at the level of certification.

Rationale: Voluntary certification identifies qualified practitioners to the public, and provides UDA protection. Level of harm to the public is insufficient to require participation (as in licensing and registration) in a regulatory program. Only those ST's who wish to work under a Practice Plan with a physician would have to certify. Certification could cite a scope of practice and level of education.

Option C: Regulate ST's at level of registration with the Secretary's professions exempting them from physician and nurse laws forbidding penetration of tissue, catheterization and/or other skills (to be named) commonly provided by ST's.

Rationale: Surgical technologists commonly work in hospitals under an employer-employee relationship. Acts which are now legal in other professions could be delegated to ST's.

Option D: Do not regulate surgical technologists.

Rationale: There is no harm to the public posed by the acts of surgical technologists sufficient to warrant state regulation of these providers. Most hospitals only hire ST's certified by the national organization. This approach clarifies issues of contention between nurses and ST's.

Issue #2: Surgical technologists are limited in their traditional role in the state of Washington because they are not exempted from performing certain tasks.

Option A: Add the following exemption clause to the physician, osteopathic physician, and nurse practice acts to allow ST's to perform the tasks of suturing, applying staples, clamping tissue, and tying or cauterizing bleeders during opening of the incision, applying dressings, and catheterization of patients.

> "It is not a violation of this act for a physician (osteopathic physician or surgeon; nurse) to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of the delegating person's license or registration or delegated authority." (Based on Minnesota Board of Medical Practice Act.)

Rationale: These tasks are taught in ST educational programs and are performed safely in 23 other states by ST's. The patient benefits from having a less costly but qualified person in the operating room.

Issue #3: Under the proposed bill, is supervision of ST's the sole responsibility of the physician named on the practice plan?

Option A: If a credentialing bill is enacted, state in the bill that ST's are responsible to their employer for all work completed at the workplace.

Rationale: The practice plan is a document allowing the ST to provide specific acts or skills under the supervision and within the scope of the named physician.

Option B: Do not add language to the bill regarding supervision in the workplace.

Rationale: The Commission or Board is responsible for developing and administering the practice plan.

When ST's are employed and sign their employment documents, the employer-employee relationship is established; therefore, the physician, while delegating tasks and managing the operation would not be supervising ST's. The circulating nurse would still be the supervisor of ancillary personnel in the operating room.

Issue #4: Are surgical technologists educated to circulate in the operating room?

Option A: If a credentialing bill is enacted, state in the bill that ST's can circulate in the operating room only when a registered nurse is immediately available within sight and hearing of the operating room and able to return immediately to assist and supervise if needed.

Rationale: At the present time, the surgical technologist circulates if a patient is under conscious sedation and only one registered nurse is available in the operating room because the nurse must constantly monitor the patient. The employer of ST's controls conditions under which employees (nurse, ST) act.

JACHO standard TX.5.3.2 addresses circulating duties in the operating room and states that "patients with lesser acuities are assigned other qualified staff members for direct care which is supervised by a registered nurse." The ST who is qualified to provide minimal circulating duties could perform those duties.

Option B: Do not add language about circulating in the operating room.

Rationale: Circulation in the operating room is the role of a registered nurse. By not adding or clarifying language, the role cannot be fulfilled by other persons. However, when a patient is under conscious sedation, the employer must be certain that another registered nurse is available for circulating duties.

Issue #5: Are surgical technologists educated to perform enhanced skills in the operating room?

Option A: If a credentialing bill is enacted, the specific acts that ST's perform can be addressed in the practice plan which is developed by the Medical Quality Assurance Commission or the Board of Osteopathic Medicine and Surgery.

Rationale: The education of ST's includes tasks performed in the assisting role such as applying dressings, sutures, staples, catheterization, clamping bleeders, and tying or cauterizing bleeders during opening of incisions. These acts are authorized by ST's in 23 other states and in the military services.

The patient would benefit in the cost of surgery compared to another person with more education and a higher salary performing the same acts.

Addendum to Options Paper, Issue #1

Option E: Regulate all surgical technologists (ST) as a Secretary's profession at the level of registration. If a ST wishes to become a surgical assistant, regulate those STs at the level of certification requiring that a certificate in surgical assisting must be obtained before certification by the state of Washington.

Rationale: All persons practicing as a ST would be regulated and their practice would be subjected to the Uniform Disciplinary Act.

Those STs who are qualified and nationally certified to be an assistant in surgery (first, second) could become certified and would then be eligible to assist the physician in surgeries. The legal acts and requirements for certification would be written in the Washington Administrative Code.

APPENDIX E

Applicant Checklist

APPLICANT CHECKLIST
WASHINGTON STATE DEPARTMENT OF HEALTH
SUNRISE REVIEW

Applicants are requested to complete this "checklist." It is designed to provide the legislature with basic information about the profession being reviewed. There may be questions not relevant to a particular applicant; in that case, just skip the question. The department staff will assist you in completing this form, as needed.

1. Legislative proposal being reviewed under the sunrise process (include bill number if available):
Registration of Certified Surgical Technologists

2. Applicant's organization: See attached document
Address: _____
_____
Contact person: _____
Telephone number: _____
Fax number: _____
Email address: _____

3. Number of members in the organization: _____
Approximate number of individuals practicing in Washington: _____

4. Name(s) and address(es) of national organization(s) with which the state organization is affiliated:
_____

Name(s) of other state organizations representing the profession:
_____
_____

5. Name and title of profession the applicant seeks to credential/institute change in scope of practice:

_____
_____
_____

List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:
(attached additional sheets as necessary)

_____ ____%
_____ ____%

_____ _____%

6. Describe the training, education and/or experience required to perform the functions of the profession (differentiate for each function/procedure as needed):

_____
_____
_____
_____
_____

7. List the titles of all other health professions that (a) perform the same type of functions, but at a different level of skill or training; (b) perform different, but related, functions in association with the profession; and (c) perform the same functions but in a different setting.

(a) _____
(b) _____
(c) _____

Add any comments about the relationship between these listed professions and the profession subject to the sunrise review: _____
_____
_____

Department of Health contact: Steve Boruchowitz, (360) 753-0719.

APPLICANT CHECKLIST

WASHINGTON STATE DEPARTMENT OF HEALTH SUNRISE REVIEW

1. Legislative proposal being reviewed under the sunrise process (include bill number if available:)

Registration of Certified Surgical Technologists in order to provide minor assisting duties at the time of surgery, at the direction of the operating surgeon RCW 18.71.030 and 18.57.040 and adding new sections to chapter RCW 18.71: and adding new sections to chapter 18.57 RCW. The above is in addition to the present scope of practice of the Certified Surgical Technologists as established by The Association of Surgical Technologists

2. Applicants Organization:
Greater Seattle Chapter #78 of the Association of Surgical Technologists Inc.
Address 12120 NE 172nd Pl. L-102, Bothell, WA. 98011-6406

Contact Person:
Jonathan F. Randolph, CST/Advanced Generalist
12120 NE. 172nd Pl, L-102, Bothell, WA 98011=6406 ,
(206) 489-9749
Janice Olmsted CST/CFA, PASA
E 90 Old Ranch Rd, Allyn, WA 98524
(360) 275-4049

E-Mail Hale Koa@AOL.Comm

3. Number of Members in the organization: 17,080
Approximate number of individuals practicing in Washington: 1314

4. Names and addresses of National Organizations with which the state organization is affiliated:
The Association of Surgical Technologists In,
7108 - C, South Alton Way
Englewood, CO 80112
1-800-637-7433

LCC-ST, Liaison Council on Certification for the Surgical Technologist
7108 -C South Alton Way
Englewood, CO 80112
1-303-694-9264
Fax:303-694-9169

Names of others representing the profession in the State of Washington:

Chapter 148, Inland Empire, Spokane WA. and Central Washington Chapter, Wenatchee, WA of the Association of Surgical Technologists, plus 180 members at large

5. Name and title of profession the applicant seeks to credential/institute change in scope of practice: Certified Surgical Technologist/CST

List and describe major functions and procedures performed by members of the profession. Indicate percentage of time typical individual spends performing each function or procedures.
a. Preparation of the operating room and the instruments, equipment and supplies, 10%
b. Passing instruments, sutures, and sponges , holding retractors, coordinating sterile needs during surgical procedure. 80%
c. assist in circulating and position and preparing the patient for surgery, at al, 5%, (If assigned to the 'scrub'role, or 100% if assigned to the circulating role)d
. d. tasks which assist the surgeon in the opening and closing incisions, providing visualization of surgical site, through retraction of tissue, suctioning wound and sponging wound. 4% when performing the "scrubrole" or 90% when assigned to assist the surgeon.
e. and other related technical functions under the supervision and control of the surgeon., including other tasks determined by the commission by rule.(clamp bleeder, operate skin wound stapler, pass guide pin under video control, coagulate bleeder by cautery, tie bleeder)1%, when assigned to the "scrub" role, or 90% when assigned to Assist the surgeon, with another person performing the scrub role. Items in para "e" are what this bill is all about. It will enable the surgeon to perform surgery , in many instances, with a Certified Surgical Technologist only.

6. Describe the training education and /or experience required to perform the functions of the profession. (differentiate for each function/procedure as needed):

A surgical technologist is trained at either a community college, or a vocational college in the state of Washington. The State presently has four institutions where this training is held. Seattle Community college, Renton Technical College, Clover Park Technical College, and Spokane Community College. In other states, similar training is received at community collages, vocational colleges and four year Universities, (U of Arkansas). The training is also provided by the United States Armed forces: Navy, Army and Air Force. Surgical Technology Courses in Washington State last 9 months to 2 years, and adhere to the guidlines established by the Accreditation Review Committee, a member of Commission on Accreditaion of Allied Health Education Programs (CAAHEP), Sponsored by the

American College of Surgeons, American Hospital Association, and Association of Surgical Technologists.

With additional education an Associated of Arts Degree can be obtained. Once the Course of Surgical Technology is completed the candidate then applies to the Liaison Council for the Certification of the Surgical Technologist to take the national certifying examination. The LCC is a member of the National Organization for Competency Assurance, the standard setting body for Credentialling in the United States. This Certification is for a 6 year period and must be renewed through continuing education process or reexamination.
The additional skills, as mentioned in part 5, may be received through preceptorship with a surgeon., or by attending one of the surgical assisting courses available in the United States, which are approved by AST,

7. List the titles of all other health professions that (a) perform the same type of functions, but at a different level of skill or training: (b) perform different, but related, functions in association with the profession, and (c) perform the same functions but in a different setting.

(a) Registered Nurse CNOR (Certified Nurse, Operating Room), Perform Peri Operative Nursing in addition to Some First Assisting

(b) Physician Assistant Work either independently or with a surgeon. as described by PA Scope of Practice, RCW

(c) Physician Assistant/Surgical Assistant Works only in the surgical suite as a First Assistant as described by RCW scope of practice

(d) M.D's. perform First assisting skills at a much higher level of training and on more critical procedures.

comments about relationship between these listed professions and the profession subject to the sunrise review.

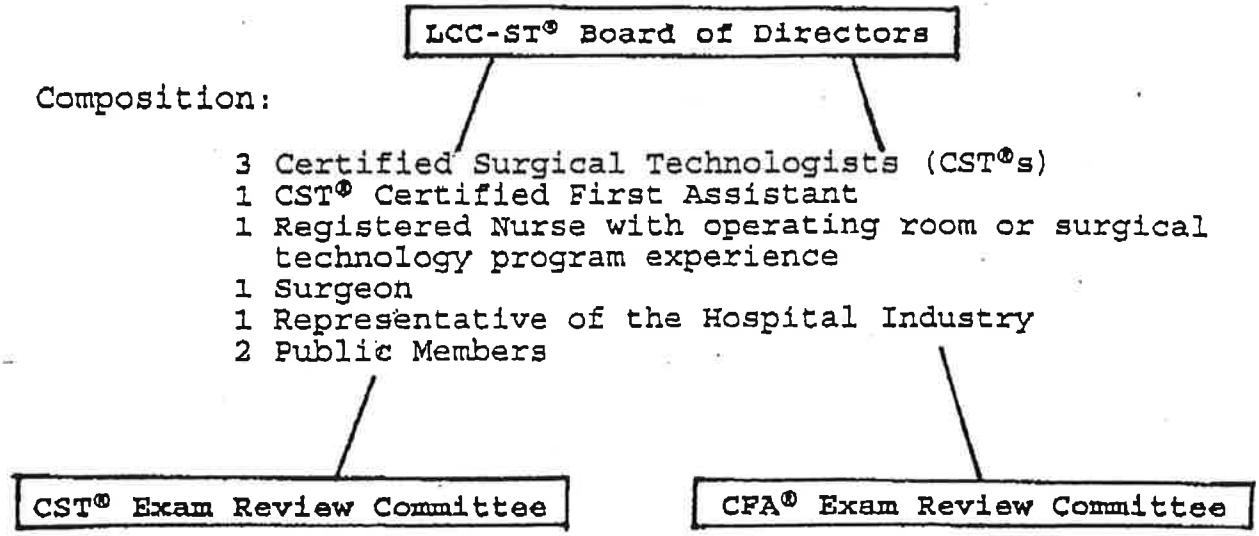
In this date of medical change many things are happening in the surgery are. In many smaller or minor surgery procedures a Surgical First Assistant is not used when a major body cavity is NOT entered. A Certified Surgical Technologist can provide the extra degree of help for the surgeon, beyond the technologists present scope of practice, in order to achieve a successful outcome. The Surgical Technologist is employed by either a medical institution or in private employment of a surgeon. The surgeon will be responsible for the actions of the CST as well as the CST will also be responsible for his own actions. Malpractice Insurance is available for the CST through the sponsorship of the AST. At present there are approximately 45,000

persons in the United States that have taken the Certification Examination.

In conclusion, the passage of this Bill will enable the Certified Surgical Technologist to Register and be able to perform the added duties as listed in Sec 5 of this application. If the CST does not want to register then he or she will not perform these EXTRA added functions at the surgery table. The passage of this Bill is not intended to eliminate or decrease the use of fellow surgery staff, IE RN's Pa's or PA/SA, but as described in the "Health Personnel Resource Plan" of Washington State, will "help eliminate legal barriers" that are restraining qualified people from providing service.

Liaison Council on Certification for the Surgical Technologist (LCC-ST®)

Organizational Structure



The LCC-ST®, a separately incorporated not-for-profit certifying agency, is solely responsible for all policy decisions regarding the certification of surgical technologists.

The CST® and CFA® Exam Review Committees are subcommittees of the LCC-ST® that are responsible for reviewing, editing, referencing, and categorizing exam questions in accordance with the exam blueprint for their respective exam. The exam review committees are assisted in their work by the professional psychometrician from the LCC-ST® testing agency, Assessment Systems Incorporated.

Both the CST® and the CST®/CFA® certification programs of the LCC-ST® have been accredited by the National Commission for Certifying Agencies (NCCA). The NCCA evaluates certifying agencies on a comprehensive set of criteria including the appropriateness of certification requirements to the occupation being certified, the validity and reliability of the certifying examinations, and the extent to which the public interest is protected. The NCCA is the accrediting body of the National Organization of Competency Assurance (NOCA).